Kawerau Medical Centre

Te Heke Mai o Te Hauora
The Future of Health Care

CASUAL REGISTRATION FORM

Family Name	Given Name	Gender M / F	Date of Birth / /	NHI
Preferred Name:		Place of Birth		
Contact Phone: Mobile:	Mobile	Day	Night	
Email:		Street Address:		
Suburb/Town:			Postcode:	
Postal Address (if different from above):				

Primary Ethnicity

☐ NZ Maori	☐ Samoan	☐ Chinese
☐ NZ European/Pakeha	☐ Niuean	☐ Indian
☐ European not defined	☐ Cook Island Maori	☐ Dutch
☐ Tongan	☐ Other Pacific Island	☐ Other

Occupation	Employer

Emergency Contact

Name:		Phone Number
Relationship:		Street Address:

Smoking is an important factor in health. Please tick the option below that best applies to you:

☐ Never Smoked ☐ Current Smoker ☐ Past Smoker – 12 months + YES / NO

If you are a current smoker, would you like help to quit? YES / NO

Where Did You Hear About Us? (Please tick one)

☐ From a friend/Word of mouth ☐ Social Media/Website ☐ Radio/Newspaper/Kawerau Echo

Other